Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN7602	A. BUILDING _____ B. WING _____	03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA NURSING AND REHAB CENTER	18805 ALBERTA DR ONEIDA, TN 37841

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 001	1200-8-6 Initial Comments During the Licensure survey conducted on March 21, 2012, at Oneida Nursing and Rehab Center, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 001		

Division of Health Care Facilities

Angela K Chitwood — Administrator — 4-3-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

APR 04 2012